Printed: 08/13/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175376		B. WING	08/-		3/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
APOSTOL	LIC CHRISTIAN HOME			AMOUNTS A, KS 6653			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS			F 000			
	The following citations represent the findings of a Health Resurvey.		s of a				
	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP		CP	F 280			
	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.						
	A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.						
	The facility identified and the sample included observation, interview	not met as evidenced bacensus of 85 resident 14 residents. Based or and record review the the care plan for 1 of 1	is.				
	Findings included:	stronic diagnosis list fro	m the				
	physician's orders las	etronic diagnosis list from the dated 3/5/13 document stipation, gastric diseas	nted				
LABORATOR	Y DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATI\	/E'S SIGNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08	/13/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
APOSTOL	LIC CHRISTIAN HOME	Ē		RAMOUNT S HA, KS 6653				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A: CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 280	dated 12/17/12 docur Brief Interview for Me 6, which indicated the impaired cognition. H with bed mobility, extransfers, walking and assistance with toiletisteady moving from a walking, turning arout toilet and with surface resident had impaired motion on one side an incontinent of urine an bowel. There was a tomanage the resident's resident had a fall in the last 6 months put to void, wore pull upsuchange the incontinent reported he/she did not toilet in time.  The CAA for falls date resident had a history assisted living. Since he/she needed assist aware of how to use to room was near the note.	and headaches.  Jum Data Set (MDS) 3.0 mented the resident with a status (BIMS) score resident had severely elshe required supervisensive assistance with a dressing and limited ang. The resident was not a seated to standing point, moving on and off the to surface transfers. The dupper extremity range and was frequently and always incontinent a colleting program used to surinary continence. The last month prior to ad a fracture related to a prior to the admission.  Jumps of incontinence.  Jumps of incontin	h a re of sion  ot sition, he rhe of of o he a fall  e olace e to t e ed the was	F 280				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER DEPLAY OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		OLIA .		LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08/1	3/2013	
	OVIDER OR SUPPLIER			RESS, CITY, STA				
APOSTOI	LIC CHRISTIAN HOME	<u>:</u>		RAMOUNT S HA, KS 665				
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F 280	extensive assistance ambulation, dressing twice since the prior at 2/14/12 directed staff assistance with transf scheduled toileting. The care plan for acti 2/14/12 directed staff assistance with transf scheduled toileting. The properties of the transfer of the trunk, lower of the trun	for bed mobility, transfer and toileting. He/she fer assessment.  Invities of daily living date of the provide 1 person fers, dressing, grooming the resident had rement with Parkinson's orgessive neurologic disting tremor, rolling of the es, shuffling gait, forward seakness) and profound atture of the spine) and et facility provided a physic example of the spine of the care plan on 2/11/13 at the care plan on 2/11/13 at the care plan to reflect ent weight bearing on the added new intervention light in reach, administed erve for side effects. The defunctioning due to a set of the spine of the spine of the different weight before the and as needed and the spine of the spine of the spine of the spine of the care plan to reflect the care plan to reflect ent weight bearing on the different weight bearing on the different provided and the spine of the spine	ed g and corder e d and sical and t the ne left s for e right e and he aff to the 0:27 nee what	F 280				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08/13	3/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE		
APOSTOL	LIC CHRISTIAN HOME	<u> </u>		RAMOUNT S HA, KS 665			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ACTION SHOULD BE O THE APPROPRIATE	
F 280	Continued From page	e 3		F 280			
	nurse's desk revealed picture of the resident did not display a pictu the recliner.	3 at 12:08 P.M. of the d a small monitor with a t's empty bed. The monure of the resident who	itor sat in				
	Observation on 8/8/13 at 12:44 P.M. revealed the resident sat in the wheelchair in his/her room.  Direct care staff T asked the resident if he/she needed to use the toilet. The resident told staff he/she was elderly and did not always know when						
	he/she needed to use the toilet and asked when the next opportunity to toilet would be. Staff informed the resident they would offer to toilet him/her before the next meal. Staff did not offer						
	instead placed the ga and transferred the re	nent to toilet the resider hit belt around the reside esident using extensive ent cues to move his/he	ent				
	feet and sit down on t	the bed. Staff lowered the Staff did not place a fa	he				
	During interview on 8/8/13 at 11:34 A.M. direct care staff U reported the resident was unsteady on his/her feet, leaned to one side and liked to do things on his/her own without calling staff for help. The video camera monitor at the nurse's desk was used by staff at night to see the resident while in bed. Staff kept the wheelchair away from the resident so he/she would be less eager to get		ady to do				
			t from				
	up without staff assist was in bed, staff lower	tance. When the reside er the bed down to the fl locking brakes on the	nt				
	nurse I reported the re	/8/13 at 11:45 A.M. lice esident was high risk fo ues, leaned to the left s	or				

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	OF DEFICIENCIES (X1) PROVIDER/SUPPL IDENTIFICATION N				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08/1	3/2013
	OVIDER OR SUPPLIER	<b>∃</b>		ESS, CITY, STA			
			SABETH	IA, KS 665	34		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F R LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	and was not aware of to transfer independed. When a resident fell is resident and filled our computer and the systematic intervention in place the nurse out of the properties of of the nurse	of safety and frequently in the safety which caused falls the nurse assessed the stan incident report in the stem made staff put a fabefore the computer all program.  8/8/13 at 3:23 P.M.  g staff D reported staff ly use a landing strip may monitor/camera at night in appropriate intervention appr	t by t. on in  view an to aff in bed.	F 280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		JRVEY TED
		175376		B. WING		08/	13/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
APOSTOL	LIC CHRISTIAN HOME	<u> </u>		RAMOUNT S HA, KS 665			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 309	The facility identified The sample included observation, record reinterviews, the facility of one (#16) residents (method to filter your Findings included:  - The electronic diagresident #16 listed Endisease condition thai irreversible damage to Heart Failure (sympto impaired left ventricul Anemia (a condition volico) blood cells to carry actissues), Atrial Fibrilla beat ) and Hypertens pressure).  The 8-5-2013 Quarte 3.0 documented a Bristatus score of 14 who was cognitively intact resident was on a toil resident was on a toil resident was occasion bowel, had a Urinary last 30 days, and recomposed to the composition of the Care Area Assess of Daily Living (ADLs documented weakness and needed greater as he/she felt that day, communicate needs we composed to the communicate needs we communicate ne	not met as evidenced by a census of 85 resident 14 residents. Based of eview and staff and residents are failed to timely assess a reviewed for Dialysis blood of harmful waste and Stage Renal Disease to the kidney), Diastolic oms of heart failure with far function), Morbid Obwithout enough healthy dequate oxygen to body attion (rapid, irregular heart inclicated the resident indicated the	for e (a e of lesity, red ly art  MDS)  ent ed the The e and the e and the ties  ties	F 309			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF PLAN OF CORRECTION IDENTIFICATION NUM			` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08/1	3/2013
NAME OF PROVIDER OR SUPPLIER  APOSTOLIC CHRISTIAN HOME			511 PAI	RESS, CITY, STA RAMOUNT S HA, KS 665	<b>БТ</b>	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	5-15-2013 documents staff to assist with toil with transfers, and chelansed the resident.  The CAA for Dehydradated 5-15-2013 documents an adequate an and the UTI was resorted. The electronic care personal form of the facility. The interest of the facility. The interest of the facility. The interest of the facility of the facility. The interest of the facility of the facility. The interest of the facility of the facility of the facility. The interest of the facility of the facility of the facility. The interest of the facility staff of a need the dressing was intained to the dressing was intained observation on 8-7-2 the resident returned observation to 2:45 Pobtain a blood pressuresident and staff did site.  The TAR from July 3-2013 documented to intact to dialysis port P.M. (on dialysis days returned) with the days returned) with the days of the care of the facility of the facili	ed the resident needed leting. Staff helped him hanged the product and t.  ation/Fluid Maintenance umented the resident w to dialysis. The resident mount of fluid during the plyed.  Ilan for dialysis dated ed the port site was on sis would weigh and reptervention dated 6-29-20 estriction of 1600 cc (cu purs. The intervention ded staff to check the	the cort on 2 dated the core core core core core core core cor	F 309			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08	/13/2013
	ROVIDER OR SUPPLIER	Ē		ESS, CITY, STA	,	•	
			SABETH	IA, KS 665	34		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 309	to check blood press week Monday, Wedrand take the blood phe/she returned from crevealed staff did not pressure and pulse a from dialysis.  The electronic nurses 8-2-2013 documented dialysis at 12:30 P.M. blood pressure and pulse and pressure and press	sure and pulse three times and pulse after dialysis. This same TAF to document the blood after the resident returned is notes signed and date of the resident returned in and staff documented bulse at 2:43 P.M. In a cumented the resident sat 12:30 P.M. and ressure and the pulse at P.M. the resident stated good day. He/she was Nursing staff did not ches/her vital signs at the subject of the pulse and puls	e AM R ed ed from the t 1:14  d s a eck rmally upper ysis at e P.M.	F 309			

FORM CMS-2567(02-99) Previous Versions Obsolete

	MENT OF DEFICIENCIES LAN OF CORRECTION  (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08/1	3/2013
	OVIDER OR SUPPLIER			RESS, CITY, STA			
				HA, KS 665			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 309	care staff S stated where the staff S stated where the staff S tares to would take him/her to CNAs do not monitor abnormal with the result the charge nurs. On 8-7-2013 at 3:15 leads when the resident care checked the site and through the bandage well we took his/her was if something was good to be staff L stated when the he/she went right to lead to be staff L staff did not his/her weight from disick he/she would let him/her for fluid intake before he/she went to problems dialysis call. There was no community that the problems dialysis call. There was no community that the problems dialysis call. There was no community that the problems dialysis call. There was no community that the problems dialysis call. There was no community that the problems dialysis call through the nursing of the check the resign of communication facility. Dialysis did here in the computer communicated verbal fax. Dialysis community is the problems of the computer communicated verbal fax. Dialysis community is the problems of the computer communicated verbal fax. Dialysis community is the problems of the problem	nen the resident came to the him/her to lunch then to their room to the toilet. The dialysis site. Anyth sident, direct care staff vise.  P.M. nursing staff K stame back from dialysis site checked for bleeding. If he/she was not feeligital signs. He/she woulgoing on.  P.M. interview with nursing te resident came back unch. After he/she was full assess his/her site to tweigh him/her. Staff ialysis. If he/she was feelight to the staff know. I monitor e also. I do vital signs to breakfast. If there was led or staff called them. Unication sheet. Nursing om dialysis was a preward not talk to them on a confrom dialysis goes office.  P.M. interview with staff D stated I expected ident back in. There was between dialysis and the his/her weights and staff.	staff ing would  ted staff ing ld tell sing s for got eeling s any g veight daily  ed as ne f put ough	F 309			

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(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_ COMPLETED 175376 B. WING 08/13/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER APOSTOLIC CHRISTIAN HOME **511 PARAMOUNT ST** SABETHA, KS 66534 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 309 F 309 Continued From page 9 consistent. I did not know if staff charted when they check his/her site. When the resident got back I expected staff to check his/her site or follow up when they got a chance. The undated facility policy for Dialysis did not specifically state nursing assessment parameters for before and after dialysis. The facility failed to assess in a timely manner for this resident that received dialysis treatment. F 323 483.25(h) FREE OF ACCIDENT F 323 SS=G HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility identified a census of 85 residents. The sample included 14 residents. Based on observation, interview and record review the facility failed to provide appropriate interventions to prevent falls for 1 of 3 residents sampled for accidents, (#48) identified to be at high risk for falls. Findings included: - Resident #48's electronic diagnosis list from the physician's orders last dated 3/5/13 documented the diagnoses of constipation, gastric disease, urinary incontinence and headaches. The admission Minimum Data Set (MDS) 3.0

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		I * *	LE CONSTRUCTION	(X3) DATE S COMPLE	
		175376		B. WING		08/	13/2013
APOSTOLIC CHRISTIAN HOME  APOSTOLIC CHRISTIAN HOME  511 PARAMOUNT ST  SABETHA, KS 66534							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	dated 12/17/12 docu Brief Interview for Me 6, which indicated th impaired cognition. I- with bed mobility, ex- transfers, walking an assistance with toilet steady moving from walking, turning arou toilet and with surface resident had impaire motion on one side a incontinent of urine a bowel. There was a to manage the resident resident had a fall in admission. He/she h in the last 6 months p  The Care Area Asse incontinence dated 1 resident had a long to He/she was able to r to void, wore pull ups change the incontine reported he/she did to toilet in time.  The CAA for falls dat resident had a histor assisted living. Since he/she needed assis aware of how to use room was near the n  The quarterly Minimu 7/29/13 documented extensive assistance	mented the resident with ental Status (BIMS) score resident had severely de/she required supervisitensive assistance with did dressing and limited ing. The resident was not a seated to standing posted ind, moving on and off the to surface transfers. To did upper extremity range and was frequently and always incontinent of the last month prior to ad a fracture related to a prior to the admission.  In the last month prior to ad a fracture related to a prior to the admission.  In the last month prior to ad a fracture related to a prior to the admission.  In the last month prior to ad a fracture related to a prior to the admission.  In the last month prior to ad a fracture related to a prior to the admission.  In the last month prior to a prior to the admission.  In the last month prior to a prior to the admission.  In the last month prior to a prior to the admission.  In the last month prior to a prior to the admission.  In the last month prior to a prior to the admission.  In the last month prior to a prior to the admission.  In the last month prior to a prior to the admission.  In the last month prior to a prior to the admission.  In the last month prior to a prior to the admission.  In the last month prior to a prior to the admission.  In the last month prior to a prior to the admission.  In the last month prior to a prior to the admission.  In the last month prior to a prior to the admission.	re of sion ot sition, the check of other of the check of	F 323			

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	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPF IDENTIFICATION  17:  16 OF PROVIDER OR SUPPLIER			A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08	/13/2013
	OVIDER OR SUPPLIER LIC CHRISTIAN HOMI	E	511 PAR	ESS, CITY, STARAMOUNT S	т	·	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 323	documented the resimplified which indicated the resimplified falls. The fall score to indicated a score high resident was high ris. Review of the Voiding revealed staff did not for incontinence and establish a voiding postablish a voiding p	sment dated 12/13/12 dent with a fall score of esident was high risk for tesident was high risk for talls provided by the fact ther than 10 represented k for falls.  g Diary dated 12/14/12 the check the resident hou complete the assessment attern indicated on the fact to provide 1 person effers, dressing, groomin The resident had irment with Parkinson's rogressive neurologic disting tremor, rolling of the es, shuffling gait, forward the spine) and the facility provided a physics shis/her gait. Staff the care plan on 2/11/13 and the facility provided a physics shis/her gait. Staff the care plan to reflect the tent weight bearing on the added new intervention light in reach, administed the resident before a me and as needed and the shoots revealed staff.	or cility d a a a a a a a a a a a a a a a a a a	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 323	Continued From page 12			F 323				
	resident was confuse lights off and pants to interventions were ad prevent the resident of On 11/17/12 at 2:43 aresident was confuse water on the floor who On 11/27/12 at 9:10 aresident was very slo required assistance to On 12/09/12 at 2:00 aresident fell walking and sustained a skin and scrape on his/het the resident to turn or but did not initiate any On 12/12/12 at 4:43 aresident fell in the bat check the resident me how often and did not interventions.  On 2/10/13 at 6:30 Paresident fell in his/her tear while attempting wheelchair. Staff initial locking brakes on the On 2/12/13 at 4:15 Aaresident on the floor but told staff his/her legs fall. Staff assessed the him/her to the bed. Staff his/her legs fall. Staff assessed the of exactly what was helphysician was notified to X-ray the resident.	A.M. staff documented and thought there was en there was not. A.M. staff documented and to comprehend things of dress. A.M. staff documented and tripped over a huminater to his/her right elber right knee. Staff instruction and the lamp before getting other fall interventions A.M. staff documented and the complete and the lamp had been determined by other fall interventions and the staff documented the complete and the lamp had been determined the room and received a set to transfer to the lated the intervention for	the as the stand the differ ow ucted ag up, s. the opecify the skin r self sident and that of anclear eleved					

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NAME OF PROVID	DER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
APOSTOLIC CHRISTIAN HOME				RAMOUNT S HA, KS 665			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	VE ACTION SHOULD BE ED TO THE APPROPRIATE	
recato on leg Recard re	are hospital for a fract the facility on 2/25/der to be 50 perceng.  Eview of the nurse's turned from the hosy vealed staff document and 3/2/13 at 10:37 A. sident frequently and hacked evidence of nean.  In 3/6/13 at 4:00 A.M. sident fell in his/her affered an abrasion of the resident was obside recliner. The call I thin reach. Staff assident fell in his/her affer without staff as a filter and then transfered and the transferent fell in his/her ansfer without staff as a for in front of the whole in the area to his/her left in the hall sold take staff to yell dany new fall internal and 1:12 P. sident fell in his/her and 1:28/13 at 1:12 P. sident fell in his/her sident fell in his/her and 1:12 P. sident fell in his/her	was admitted to an acuctured right hip and returned 13 at 1:30 P.M. with an at weight bearing on the notes after the resident spital with the broken hip ented the following:  M. staff documented the	e e ecord care  d oot. ont of e bed o the ed. o new e to he add e lost e lost e e it oot. on. e d on. e e d on.	F 323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	175376			B. WING		08/	13/2013	
NAME OF PF	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
APOSTO	LIC CHRISTIAN HOME	Ĭ.		RAMOUNT S HA, KS 665				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	documented the seven noncompliant with as Staff instructed the re No new interventions plan to prevent furthe On 7/8/13 at 8:56 P.M resident fell in his/her assistance and the recaused by a loss of bresident to wait for as light. Staff did not add the care plan to preven On 7/14/13 at 5:15 P. resident fell while atterno himself/herself. The resident fell while atterno new interventions Staff did not assess to establish the need toileting plan. On 7/24/13 at 8:00 P. resident fell in the bath himself/herself and so on the back of his/her resident on the bathrohis/her pants pulled provement on the grostaff emphasized to tresident the important assistance. Staff did to bowel and bladder vointerventions to the cafalls.  Observation on 8/8/13 resident sat in the recomposition on 8/8/13 resident sat in the rec	erely impaired resident of king staff for assistance is sident to use the call light were added to the care falls.  M. staff documented the room walking without sesident reported the fall alance. Staff reminded is sistance and use the cod any new interventions ent further falls.  M. staff documented the end any new interventions ent further falls.  M. staff documented the end of the end of the care he resident to call for help were added to the care he resident's voiding particular and staff documented the throom attempting to to defer head. Staff observed to the compliance of using the call light not assess the resident siding pattern or add an are plan to prevent furth.  3 at 12:07 P.M. revealed.	estaff was the all to and eplan. attern  attern  he staft  y new her  ad the	F 323				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
	175376			B. WING		08/	08/13/2013	
APOSTOLIC CHRISTIAN HOME				RESS, CITY, STA RAMOUNT S HA, KS 665	<b>БТ</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	did not display a pictus the recliner.  Observation on 8/8/1 resident sat in the who Direct care staff T as needed to use the toin he/she was elderly an he/she needed to use the next opportunity to informed the resident him/her before the neanymore encouragen instead placed the gas and transferred the reassistance and frequented and sit down on bed down to the floor mat by the resident's  During interview on 8 care staff U reported on his/her feet, leane things on his/her own The video camera mowns used by staff at rewhile in bed. Staff key the resident so he/shup without staff assis was in bed, staff lower The resident had self wheelchair.  During interview on 8 nurse I reported the realls, had balance iss and was not aware of to transfer independed When a resident fell to the staff and the staff independed when a resident fell to the staff and the staff independed when a resident fell to the staff are staff independed when a resident fell to the staff and the staff independed when a resident fell to the staff and the staff independed when a resident fell to the staff and the staff independed when a resident fell to the staff and the staff independent in the staff and the	are of the resident who shall be a state of the resident in his/her room ked the resident if he/shall be a stand did not always know the toilet and asked who to toilet would be. Staff at they would offer to toile be a staff did not offer to toilet to toilet the resider and the resider and the resider and the state of the total between the total be asked to move his/her to the bed. Staff lowered the staff did not place a fatter the staff did not place a fatte	ed the n. ne aff when hen et ffer nt, but ent er he all ect addy to do help. sk t from o get nt loor.	F 323				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
711121 27111 01	CONTROL							
		175376		B. WING		08/1	3/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
APOSTOLIC CHRISTIAN HOME				RAMOUNT S				
			SABEI	HA, KS 665	34 			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323	3 Continued From page 16			F 323				
F 323	computer and the systintervention in place to the nurse out of the phallucinations in the president had a pad all back in December 20 interventions such as way to the floor, the reas they could get it to video monitor at night Staff reported the resincontinent and did faindependently. He/she diary was incomplete assess the resident's voiding pattern.  During interview on 8 care staff T reported to falls and staff provide transfers, toileting the meals, and the reside other times or indepetry to get to the toilet.  During interview on 8 administrative nursing	stem made staff put a fate before the computer allowance and was confused. The resident hast and was confused. The staff discontinuous arm which staff discontinuous arm was as a staff discontinuous arm was as a staff discontinuous and staff discontinuous arm was at risk discontinuous at a staff discontinuous arm was at risk discontinuous at a staff discontinuous arm was at risk discontinuous at a staff discontinuous at a s	owed ad The inued inued all the close e. iding ughly sh a ect for for ter id and	F 323				
	had tried to get rid of body alarms and there were only 2 pad alarms in the entire facility now. This resident had alarms which staff thought caused the resident more confusion so they discontinued them. Soon they planned to do a trial alarm with							

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C		` ′	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		175376 B. WING 08/13/2				3/2013	
	OVIDER OR SUPPLIER	E	511 PA	RESS, CITY, STA RAMOUNT S HA, KS 6653	вт	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	educate the resident appropriate intervent the resident fell and updated when the reand was incontinent routine voiding diary a voiding pattern. St diary upon the reside with significant chan monitor with them do the day when the resident reventions for the mat.  On 8/12/13 at 10:16 attempted with consthe physician was not the physician was not the facility provided entitled Fall Risk Ast to institute interventiat risk for falls.  The facility failed to new interventions for impaired resident's fresulting in a fracture interventions as plant 483.25(I) DRUG RE UNNECESSARY DRUNNECESSARY DRUNNECESSAR	t, but should have put m tions in place after each the care plan needed esident fell going to the t. The facility did not institute a sea after a fall to deterraff should complete a voent's admission, yearly ages. Staff should take the uring the night, but not disident was out of bed. ed 5/10/13 lacked monitoring of a fall land.  A.M. an interview was ultant physician II, howe of available for interview a policy without a date sessment which directed ons for residents found falls to prevent further fall and failed to utilize fall nined.  GIMEN IS FREE FROM	time oilet tute mine biding and ne uring ing  ever  d staff to be eve eve s any g g g g g or quate	F 329			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER			1 1	E CONSTRUCTION	(X3) DATE SI COMPLE		
	175376 B. WING				08/	08/13/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
APOSTOLIC CHRISTIAN HOME				RAMOUNT S IA, KS 6653			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F R LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329	combinations of the resident, the facility resident these drugs untherapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral intervention	reasons above.  The sensive assessment of a must ensure that resider antipsychotic drugs are reless antipsychotic drug to treat a specific conduction of the clinical sension who use antipsychotical dose reductions, and	nts not ition	F 329			
	This Requirement is not met as evidenced by: The facility identified a census of 85 residents. The sample included 5 residents for medication review. Based on observation, record review and interview the facility failed to effectively monitor medications for Black Boxed Warnings (BBW) for 4 (#53, #58, #28, #7) of the 5 residents reviewed for unnecessary medications.						
	dated 5/20/13 listed to resident #53: demendisorder characterized confusion) with behald disorder (a subtype oby the inability to find combined with physical decreased appetite).	er Recertification Sheet the following diagnoses tia (progressive mental ed by failing memory, viors and episodic moo of depression characteri d pleasure in positive thi cal agitation, insomnia, and traumatic arthropat ma, characterized by a	for d zed ngs or				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUM				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	175376 B. WING		08/1	13/2013			
	OVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	TE, ZIP CODE		
APOSTOL	LIC CHRISTIAN HOME	<u> </u>		AMOUNT S IA, KS 6653			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY I REGULATORY OR LSC IDENTIFYING INFORMA			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	hemorrhage, capsular swelling and distention, followed by adhesions, granulation tissue, and ossification of the joint).			F 329			
	The quarterly Minimum Data Set 3.0 with assessment reference date of 7/15/13 listed the Brief Interview for Mental Score as 7, which indicated severe cognitive impairment, mood score was 4 minimal depression, and had no behaviors. He/she had pain frequently which interfered with his/her day to day activities, rated pain worst at a 10 on 1 to 10 scale, with 10 being the highest score for pain. The resident received antidepressant (medication used in the treatment of depression and other conditions) and anti-psychotic (medication used to treat psychosis [any major mental disorder characterized by a gross impairment in reality testing] and other mental and emotional conditions) medication daily.						
	The Care Area Assessment (CAA) dated 4/25/13 for delirium listed the resident was demented with rather volatile mood at times and could get quite agitated. He/she received medications for this to help keep his/her mood less explosive.		d with juite				
	The CAA for behavior dated 4/25/13 noted staff redirected the resident when needed, the resident had a long standing history of delusions (an untrue persistent belief or perception held by a person although evidence shows it is untrue) and hallucinations (sensing things while awake that appear to be real, but instead have been created by the mind).		sident  a  a  and  nat				
		ropic medication (a on used to treat or man or challenging behavio	- 1				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER				E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08/	13/2013	
	OVIDER OR SUPPLIER			ESS, CITY, STA				
APOSTOLIC CHRISTIAN HOME				RAMOUNT S IA, KS 6653				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F R LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 329	dated 4/25/13 noted anti-psychotic and ar He/she needed the nand emotional comformation standing psychotic point in the care plan for potential pain, document pain effectiveness, assist encourage rest period. The Activities of Daily dated 6/29/13 and la for staff to assist with and manifested by A resident's cognitive lefunctional level, and encourage the reside keep the call light in meals, at bedtime, as of the night shift. The the overhead light in times due to his/her pof the dark. There wo fithe dark. There wo fithe bed to assist the and promote indepersion of the identified medication by light Administration Record label of the medication the effectiveness medications every 60 medication	the resident received ntidepressant medication nedications for quality of the total problems.  The resident received nedications for quality of the total problems.  The resident of the received total problems.  The resident reposition for construction with repositioning, ds, and position for constructions of the resident of the resi	af life  lated  e the  nfort.  n noted entia, es the  s to to after bund ested all ess side ning  9/13 of tify  ne cian w side	F 329				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08/1	3/2013	
	OVIDER OR SUPPLIER			ESS, CITY, STA	•			
APOSTOL	LIC CHRISTIAN HOME	:		RAMOUNT S HA, KS 665				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 329	Mirtazapine, Norco/Lo Fentanyl.  Review of the August physician recapitulation identified the following Mirtazapine 15 milligr hour of sleep (HS) for of 6/27/11.  Seroquel 25 mg orally disorder with start data 6/27/11, Fentanyl 12 micrograpatch transdermal evochronic pain with start Review of Drug Inform Nursing dated 2011, following BBWs: Seroquel warning/pre Boxed Warning]: "Eld dementia-related psynanti-psychotic are at a compared to placebo'  Fentanyl transdermal warning/precautions ["Indicated for the mamoderate-to-severe pain control is needed period. Should only balready receiving opic tolerant, and who requivalent to 25 mcg/Contraindicated in patolerant, in the managanalgesia, or in the mpain. Should be applied.	2013 MAR and the on order sheet dated 5/g medications with BBV am (mg) one tab orally depression with start of at HS for psychotic marker of the medication (mcg/hr) 1 and the medication (mcg/hr) 1 are y 3 days at 11:00 A.M. It date of 12/28/11.  Ination Handbook for 12 th Edition, listed the cautions [U.S. Blacked derly patient with chosis treated with the mincreased risk of death of the medication of the medication when around the class of the medication when around the class of the medication of the medicatio	V: at date ood  //. for ath ning]: cock o are id rative Use	F 329				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	175376			B. WING	08/13/2013	
	OVIDER OR SUPPLIER LIC CHRISTIAN HOME	<u>:</u>		ESS, CITY, STA RAMOUNT S IA, KS 665	ВТ	
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F 329	Continued From pag	e 22		F 329		
	resident sat in the bar Staff stopped in and the right back to help. The understanding.  On 8/7/13 at 3:10 P.M. out to the nurse's state he/she got his/her nesmiled and was please.  Observation on 8/8/1 resident exercised with resident exercised with resident smiled, cheef breakfast and wanted knew it would go right.  Interview with direct of P.M. said the resident impatient, or upset with the resident was stated to the resident impatient, or upset with the resident impatient, or upset with the resident in the resident impatient, or upset with the resident in the resident in the resident impatient, or upset with the resident in th	M. the resident propelled tion, questioning when xt pain pill. The resider sant to staff.  3 at 7:45 A.M. revealed th staff supervision. Therful and said he/she loved to ask for seconds but to his/her middle.  The staff P on 8/7/13 are staff P on 8/7/13 are staff especially wher it staff especially wher	d self  the  t 3:46  is,			
		n pill and it was not time not really show any oth	II.			
	at 4:42 P.M. said the	vith licensed nursing sta staff wrote the BBW of the medication but not to tion on the care plan.	n the			
	said it was "to ensue monitored on all med	policy for Black Box Wa that adverse side effect ications listed under thi of failed to identify care effects for BBW	ts are			
		nonitor and care plan fo g side effects for Seroqu cognitively impaired				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	175376			B. WING		08/13/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
APOSTOL					ST 34		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 329	dated 5/20/13 listed the resident #58: dement disorder characterized confusion) with behandiabetes (when the buthere was not enough	er Recertification Sheet he following diagnoses tia (progressive mental	for e,	F 329			
	The quarterly Minimuthe assessment refer the Brief Interview for which indicated he/sh. The resident exhibite mood score of 1 which depression. The resident exhibite mood score of 1 which depression.	im Data Set (MDS) 3.0 rence date of 7/1/13 lister Mental Status score of the was cognitively intacted no behaviors and had	with ed f 13 t. d a				
	for psychotropic med resident received ant antidepressants med notes, psychiatric me behaviors and physic facility attempted to c past, the resident bed more delusional and life.	i-psychotic and ications. Refer to the nediation evaluations, and cian progress notes whe lecrease medications in came very agitated and it affected his/her qualit	urses d en the n the even even				
		ck Boxed Warnings (BE 2 noted for staff to mon					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION	(X3) DATE S COMPLE			
		175376		B. WING	08/13/2013		13/2013		
	OVIDER OR SUPPLIER LIC CHRISTIAN HOM	E	511 PAI	ADDRESS, CITY, STATE, ZIP CODE  PARAMOUNT ST  BETHA, KS 66534					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 329	the side effects of the be able to identify the the Medication Admithe red dot on the method physician on effective review medications of days. The medication were Coumadin, Method Tylenol/Acetaminophysician for Cohistory of deep vein 17/5/13. Staff to asseredness and pain, giobserve for side effedermatitis, urticaria, nausea/vomiting, heapain/redness.  Review of the Augus physician recapitulate identified the following Metformin 500 millight wice daily for diabet 4/6/11 Celexa 10 mg one to the depression with start Warfarin 5 mg one to the thrombosis (clot) with Seroquel 50 mg one and 9:00 P.M for ps 3/8/12  Review of Drug Infor Nursing dated 2011, following BBWs: Metformin warning/p Warning]: "Lactic acid	e identified medications, a medication Record (MAR edication label, to work eness of medications, a with the physician everyons listed on the care platformin, men, Celexa, and Seroque madin/Warfarin used fithrombosis was last dates arms and legs for exemple medication as ordered to such as hemorrhage anorexia, hematuria, adache, and report leg anorexia, hematuria, adache, and report leg medications with BBV rams (mg) one tab orally es mellitus with start date of 4/21/11 ablet at 6:30 P.M. for a start date of 4/18/12 tab twice daily at 8:00 A sychosis with start date of 4/18/12 tab twice daily at 8:00 A sychosis w	ng on ) and with nd 60 an uel. or ed ed, ed, y te of	F 329					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08/	13/2013
	OVIDER OR SUPPLIER		STREET ADDRI		•		
APOSTOL	LIC CHRISTIAN HOME			AMOUNT S A, KS 665			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LISC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	Continued From pag	e 25		F 329			
	Black Boxed Warning include high intensity laboratory blood testratio), variable INRs, bleeding (bleeding in tract), hypertension (lanemia (a condition value), malignancy (a cells/cancerous grow insufficiency (inability waste), drug to drug is therapy or known ger (human enzyme) action of the condition of the c	with out enough healthy dequate oxygen to the laborated abnormal rapid growth of th), trauma, renal or of the kidneys to excresinteractions, long duratinetic deficiency in CYP2	ding a a ed al ye red boody of ete on of 2C9				
	Observed the resider resting quietly in bed,	nt on 8/7/13 at 3:52 P.M , eyes closed.	I.				
	resident sat in a chair	3 at 7:38 A.M. revealed r in his/her room, had a id he/she was waiting fo					
	at 4:42 P.M. said the	with licensed nursing sta staff wrote the BBW or medication but not the tion on the care plan.	the				
	said it was "to ensue monitored on all med	policy for Black Box Wa that adverse side effect ications listed under thit y failed to identify care	ts are				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
	175376			B. WING	<u></u>	08/	3/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	<u> </u>		
APOSTOL	IC CHRISTIAN HOME			RAMOUNT S HA, KS 665				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	Continued From page	e 26		F 329				
	planning for the side of medications.							
	The facility failed to monitor and care plan for Black Boxed Warning side effects for Metformin and Warfarin for this resident.							
	1-24-2012 documente irregular heart beat), I Hemorrhage (inflamm the colon, which caus bowel function), Anxie emotional reaction chapprehension, uncerta Esophageal reflux (a stomach contents lea stomach into the esop (elevated blood press (condition of elevated Secretion, Alzheimer's mental deterioration of	aracterized by ainty and irrational fear condition in which the k backwards from the chagus), Hypertension cure), Hyperlipidemia blood lipid levels), Sali s Disease (progressive characterized by confus and Malignant Neoplas	oid, out m, in e in ),					
	assessment dated 7-2 Interview of Mental St of 7 indicating severe The MDS documente depressed or hopeles energy. No behaviora care, or wandering be MDS documented dia Depression (abnorma characterized by exag sadness, worthlessne than Bipolar) and med in the last seven days	al symptoms, rejection of chaviors documented. Ignosis Anxiety disorde all emotional state ggerated feelings of less and emptiness) (oth dications resident received	score n. or The r and er					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08/	13/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
APOSTOL	IC CHRISTIAN HOME			RAMOUNT S HA, KS 665				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	Continued From page	e 27		F 329				
	The Care Area Asses (sudden severe confurestlessness) dated 1 resident had no signs did have cognition los slowly.  The CAA for Cognitive documented the reside confusion but no delir was normally alert an at times and needed with his/her Alzheime  The CAA for Psychos 11-14-12 documented anxiety at times. He/s being nauseated or ill it was usually anxiety feeling fine to not very one on one attention, him/her to get up and he/she felt fine and we took scheduled ativar was on antidepressar.  The CAA for Psychoto 11-14-12 documented history with depression	esment (CAA) for Delirication, disorientation and 1-14-2012 documented of delirium. The resides but that had occurred to be Loss dated 11-14-12 lent had episodes of ium noted. The resided oriented and was forgues. This was expected to the resident did have she often complained of and staff felt at those to the could go from y well, quickly and if gives taff could generally of dress and eat and there as pleasant. The resident (used to treat anxiety) int.	d the ent d d d d d d d d d d d d d d d d d d d					
	documented Ativan 0 mouth twice a day for 5-14-2012 Mirtazapin mouth daily at bedtim	sians Orders dated 5-1- .5 milligrams tablet by Anxietyteeth grinding e 15 milligram tablet by e for Depression Black serve patient for worse	g; , Box					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08.	/13/2013	
	OVIDER OR SUPPLIER	F		RESS, CITY, STATE				
, oo.o.		_		HA, KS 66534				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F R LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	6-19-2013 Coumadin mouth six times a we Sunday, Thursday, Tell caregivers to water abnormal bruising-noted 6-24-2013 Warfarin (2 tablet/5 milligrams Monday for Atrial Fiboran cause major or fregularly. Tell caregivers and subsequently.  The Care Plan for Bl Medications dated 15 monitor the side effect medications, to be all medications by the lining highlighted in red, we effectiveness of medications with phyefficacy and side effect oumadin, Lortab. Specific side effects of the coumadin, Lortab. Specific side effects of the coumadin of the side effect of the coumadin, Lortab. The coumading activity and the country and the coun	n 2.5 milligram tablet by eek Friday, Saturday, Fuesday and Wednesda ck Box Warning: can cang. Monitor INR regular atch for signs of bleeding of the form of the f	y for nuse ly. g or ablet week ning: NR of  V)  were  r on, e plan on. eay o the d. ch d, in the	F 329				

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		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175376		B. WING	<del></del>	08/13/2013		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
APOSTOL	LIC CHRISTIAN HOME	<u> </u>		RAMOUNT S HA, KS 665				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 329	specific side effects.  The undated facility procedure Black Box care planing black box. The facility failed to coff the BBW medication.  The electronic recordocumented diagnost (abnormal emotional exaggerated feelings dejection, worthlessn hopelessness), Anxietreaction characterized uncertainty and irration disorder (a major medication people to have episor moods).  The Annual Minimum 5/20/13 revealed a Bis Status score of 10 (in cognition).  The Care Area Assessor mood revealed immaking.  Psychotropic medication revealed a long standard depression.  The signed medication 5/20/13 revealed Depfor severe high and long standard people for severe high and lon	provided policy and Warning did not address ox warning side effects. Fare plan for the side effects. For a state characterized by the of sadness, melancholytess, emptiness and ety (a mental or emotion did by apprehension, and Mild Bipontal illness that causes des of severe high and a Data Set (MDS) 3.0 dated Interview for Mental indicated moderately impossment (CAA) dated 2/2 apaired daily decision tion CAA dated 2/25/13 ding history of severe are on recertification dated bakote (a medication gives moods) by mouth two	ler y, nal plar low ated paired 25/13	F 329				
	day which had a Blac	ow moods) by mouth tw ck Box Warning (BBW) on so of malaise (vague und	of					

FORM CMS-2567(02-99) Previous Versions Obsolete

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08/	13/2013
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•	
APOSTOL	LIC CHRISTIAN HON	<b>IE</b>		RAMOUNT S IA, KS 6653			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	feeling of body weal fever (elevated tempedema and to perform therapy and at frequency for the feet of	kness, distress or disconperature), anorexia, faciarm liver function test pricuent intervals for the first information Handbook for on, noted the following B pakote: Hepatic failure is had occurred in patients and dated 5/24/13 for BW, included staff were cation by the listing on the dication with the physic fficacy and side effects. The black box warning medication.  If 3 at 9:15 A.M. the residing in the hallway and called name. Staff reassured to the breakfast meal.  B-8-13 at 2:52 P.M. state in the warning medication in the dining room and the breakfast meal.  B-8-13 at 2:52 P.M. state is were on the MAR, and ms were just listed and he warning did not addresox warning side effects.  Care plan for the side effects.	al al arto 6 6 able e cian Fhe g side lent ed for he was d, in the ad no	F 329			
F 425	483.60(a),(b) PHAR	RMACEUTICAL SVC -		F 425			

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA		1 ' '	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBE	iK.	A. BUILDING		COMPLET	ED	
		175376		B. WING		08/1	3/2013	
	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
APOSTOL	IC CHRISTIAN HOME	:		RAMOUNT S HA, KS 665				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 425 SS=D	ACCURATE PROCEI  The facility must providugs and biologicals them under an agreei §483.75(h) of this par unlicensed personnel law permits, but only supervision of a license A facility must provide (including procedures acquiring, receiving, cadministering of all drithe needs of each resulting the facility must empa licensed pharmaciston all aspects of the provides in the facility.  This Requirement is The facility identified and Medication administrations.	ide routine and emerge to its residents, or obtainent described in t. The facility may perroused to administer drugs if Sunder the general sed nurse.  The pharmaceutical services that assure the accuratispensing, and trugs and biologicals) to sident.  Idea of the services the accuration of pharmacy to the services of	nit State es te meet es of ation	F 425				
	Administration Record of the sample.	•						
	Findings included:  - The electronic physician's order dated 4/5/11 for resident #4, revealed and order for Hyoscyamine Sulfate elixir 0.25 milligrams per enteral tube four times a day as needed for increased secretions.							

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		175376		B. WING	·	08/13/2013
	OVIDER OR SUPPLIER LIC CHRISTIAN HOM	E	511 PAR	RAMOUNT S	ST .	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMA		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 425	Continued From page	ge 32		F 425		
	Sulfate elixir 0.25 mi a day, instead of the Observation on 8/6/7 H prepared and adm Sulfate elixir per enter Interview on 8/6/13 a stated we have not glong time to this residung time to this residung time to the residung time to the stated the medication in April 2011. He/she order dated 4/5/11 list tube.  Administrative staff E stated when the order dated when the staff E stated when the order to the content of the stated when the order date of the content of the c	13 at 2:00 P.M. licensed ninistered Hyoscyamine eral tube. at 2:00 P.M. licensed stagiven anything by mouth	I staff  aff H I for a  I.			
	transcription of phys					
	The facility failed to ophysician's order to	correctly transcribe a the MAR.				
	483.60(c) DRUG RE IRREGULAR, ACT (	EGIMEN REVIEW, REPO ON	ORT	F 428		
		f each resident must be ce a month by a license	d			
	I	st report any irregularities	s to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE S COMPL	
	175376		B. WING		08	/13/2013
NAME OF PROVIDER OR SUPPLIER  APOSTOLIC CHRISTIAN HOME		511 PAF	RAMOUNT S HA, KS 6653	Т		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
This Requirement is referred to the sample included of the sample included.  The Physician Order dated 5/20/13 listed the resident #53: demention disorder characterized confusion) with behave disorder (a subtype of by the inability to find combined with physical included of the sample of the sampl	not met as evidenced to a census of 85 residents for medical servation, record reviewabled to effectively moni Boxed Warnings (BBV of the 5 residents reviecations.  The Recertification Sheet the following diagnoses a (progressive mental diby failing memory, iors and episodic mooi depression characteripleasure in positive thial agitation, insomnia, and traumatic arthropations.	by: ts. tion w and itor V) for ewed  for  d zed ngs or	F 428	DEFICIEN		
followed by adhesions ossification of the join!  The quarterly Minimur assessment reference Brief Interview for Mer indicated severe cogn score was 4 minimal of	r swelling and distentions, granulation tissue, and the date of 7/15/13 listed intal Score as 7, which ditive impairment, mood depression, and had not day to day activities, r	the d o h ated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		175376		B. WING			3/2013	
	0.4050 00 0.4004.50	<u> </u>	CTDEET ADD	RESS, CITY, STA	TE ZID CODE	1 00/	0/2010	
	OVIDER OR SUPPLIER LIC CHRISTIAN HOME			RAMOUNT S				
AFOSTOL	IC CHRISTIAN HOME	•		HA, KS 665				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	COMPLETION DATE	
F 428	Continued From page	e 34		F 428				
	antidepressant (medic of depression and oth anti-psychotic (medica [any major mental dis gross impairment in re mental and emotional daily.	ation used to treat psycorder characterized by eality testing] and other I conditions) medication	ment chosis a					
	The Care Area Assessment (CAA) dated 4/25/13 for delirium listed the resident was demented with rather volatile mood at times and could get quite agitated. He/she received medications for this to help keep his/her mood less explosive.							
	The CAA for behavior dated 4/25/13 noted staff redirected the resident when needed, the resident had long standing history of delusions (an untrue persistent belief or perception held by a person although evidence shows it is untrue) and hallucinations (sensing things while awake that appear to be real, but instead have been created by the mind).							
	psychiatric symptom of dated 4/25/13 noted than ti-psychotic and an	on used to treat or man- or challenging behavior he resident received tidepressant medication redications for quality of the due to his/her long	ns.					
	7/19/13 noted the pair degenerative disc disc pain, document pain I effectiveness, assist v	ease, Staff to describe evel, chart medication	the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		175376		B. WING	<del> </del>	08/13/2013		
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
APOSTO	LIC CHRISTIAN HOME	Ē		PARAMOUNT ST ETHA, KS 66534				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 428	The Activities of Daily dated 6/29/13 and last for staff to assist with and manifested by Al resident's cognitive let functional level, and dencourage the reside keep the call light in meals, at bedtime, as of the night shift. The the overhead light in times due to his/her portion of the dark. There was of the bed to assist the and promote independent of the medications by list Administration Recordabel of the medication on the effectiveness of medications every 60 effects, and a goal of from the medications Mirtazapine, Norco/Lefentanyl.  Review of the August physician recapitulation identified the following Mirtazapine 15 milligrical hour of sleep (HS) for of 6/27/11.  Seroquel 25 mg orally disorder with start dat 6/27/11.	A Living (ADL) care plans of reviewed on 7/19/13 ADLs, related to deme DL participation. Assessivel, note changes in offer simple instructions and to participate. Staff is reach, toilet before and a needed and the first reach, toilet before and a needed and the first reach, toilet before and a needed and the first reach, toilet before and a needed and the first reach resident's family request the room remain on at a needed and the left shad as a half rail to the left shad as a half rail to the left shad are resident with position and eresident with position and the original date of cent review date of 7/18 initored the side effects tions, were able to identify and the red dot on the on, work with the physic of the medication, reviewed and adverse side effects. Medications listed: ortab, Seroquel, and	noted entia, sis the sto to to after bund ested all ess side es	F 428				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			A. BUILDING	LE CONSTRUCTION	(X3) DATE SUF COMPLETI		
		175376		B. WING		08/1	3/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
APOSTOL	LIC CHRISTIAN HOM	E		AMOUNT S IA, KS 665			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	patch transdermal exchronic pain with stal Review of Drug Infor Nursing dated 2011, following BBWs: Seroquel warning/pre Boxed Warning]: "Edementia-related psy anti-psychotic are at compared to placebo Fentanyl transdermal warning/precautions Warning]: "Indicated persistent moderate- the clock pain control time period. Should are already receiving tolerant, and who recequivalent to 25 mcg Contraindicated in patolerant, in the mana analgesia, or in the r pain. Should be app of a patch that has b in any way may resu Review of the Drug F monthly from 7/19/12 documentation relate Observation on 8/7/1 resident sat in the ba Staff stopped in and right back to help. T understanding.	very 3 days at 11:00 A.M. rit date of 12/28/11.  rmation Handbook for 12 th Edition, listed the ecautions [U.S. Blacked Iderly patient with ychosis treated with an increased risk of dea o".  al patches [U.S. Blacked Boxed for the management of to-severe pain when are old is needed for an exten only be used for patients gopioid therapy, are opi quire a total daily dose gohr transferal patch. atients who are not opio agement of short term management of postope olied only to intact skin. Heen cut, damaged, or al alt in overdose".  Regimen Review dated 2 to 7/3/13 revealed no led to BBW monitoring.  13 at 7:10 A.M. revealed athroom, the call light wa told him/her they would the resident voiced	ound ded s who oid ded latered	F 428			
		M. the resident propelled ation, questioning when	u seli				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMB		JLIA .		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08/	13/2013
	OVIDER OR SUPPLIER LIC CHRISTIAN HOMI	Ē	511 PAF	RESS, CITY, STA RAMOUNT S HA, KS 6653	т		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	he/she got his/her ne smiled and was plea:  Observation on 8/8/1 resident exercised w resident smiled, chee breakfast and wanter knew it would go right and the resident impatient, or upset whe/she wanted a pair yet but otherwise did behaviors.  Interview on 8/7/13 v 4:42 P.M. said the st MAR and only listed BBW for that medical An interview on 8/8/1 consultant HH said heresidents' chart for unmonthly, collected dasheet, laboratory resinotes, and the historinot review the resident The undated facility paid it was "to ensue monitored on all medicategory". The policiplanning for the side medications.  Consultant HH failed the facility not monitored the facility no	ext pain pill. The resident sant to staff.  3 at 7:45 A.M. revealed ith staff supervision. Therful and said he/she look to ask for seconds but it to his/her middle.  care staff P on 8/7/13 a not sometimes got anxious ith staff especially when it is pill and it was not time not really show any other with licensed nursing staff wrote the BBW on the medication but not it iton on the care plan.  3 at 2:55 P.M. with the medication but not it iton on the care plan.  3 at 2:55 P.M. with the incessary medications at a from the physician's ults, physician progress y and physical. He/she ints' care plans.  5 colicy for Black Box Wathat adverse side effect incations listed under this y failed to identify care effects for BBW  5 to identify the irregularioning for Black Boxed for Seroquel and Fental	If the ne wed t 3:46 us, ne for it ner aff I at ne the sorder is did rning ts are is	F 428			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBE					(X3) DATE SURVEY COMPLETED	
	175376		B. WING		08/13/2013	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRE				
APOSTOLIC CHRISTIAN HOME			AMOUNT S A, KS 6653			
PREFIX (EACH DEFICIENCY MU	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 428 Continued From page 38	3		F 428			
- The Physician Order Redated 5/20/13 listed the foresident #58: dementia (president #58: dementia for president #58: dementia for president #58: dementia for president	collowing diagnoses for orgressive mental of failing memory, disturbance, type 2 can not use glucose sulin made or the bod sulin), and venous condition in which a vessel).  Data Set (MDS) 3.0 we date of 7/1/13 lister and status score of vas cognitively intact. To behaviors and had adicated minimal at received anti-psychological conditions. Refer to the nution evaluations, and progress notes where ease medications in the very agitated and effected his/her quality.  Boxed Warnings (BBN oted for staff to monit entified medications, the dication by the listing ation Record (MAR) ation label, to work we were served.	clot  cith d 13 a notic, is. 0/13  arses in the the even c of  W) tor to g on and cith				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			A. BUILDING		(X3) DATE SURVEY COMPLETED		
		175376		B. WING		08/13	/2013
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
APOSTO	LIC CHRISTIAN HOM	E		RAMOUNT S IA, KS 6653			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	review medications of days. The medication were Coumadin, Me Tylenol/Acetaminoph The care plan for Cohistory of deep vein 7/5/13. Staff to asseredness and pain, gi observe for side effedermatitis, urticaria, nausea/vomiting, he pain/redness.  Review of the Augus physician recapitulatidentified the followir Metformin 500 millig twice daily for diabet 4/6/11 Celexa 10 mg one tadepression with start Warfarin 5 mg one tathrombosis (clot) with Seroquel 50 mg one and 9:00 P.M for ps 3/8/12  Review of Drug Infor Nursing dated 2011, following BBWs: Metformin warning/p Warning]: "Lactic acid in the body) is a consequence of ther Warfarin/Coumadin Black Boxed Warnin include high intensity	with the physician every ons listed on the care platformin, men, Celexa, and Seroque numadin/Warfarin used fithrombosis was last dates arms and legs for eve medication as orderects such as hemorrhage anorexia, hematuria, adache, and report leg at 2013 MAR and the sion order sheet dated 5 mg medications with BBV rams (mg) one tab orally es mellitus with start dates at hour of sleep for	an uel. or ed ed, ed, e, /20/13 V: / te of  Boxed nuch vere S. eding ed	F 428			

	(X3) DATE SURVEY COMPLETED	
175376 B. WING 08/13/2	2013	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
APOSTOLIC CHRISTIAN HOME 511 PARAMOUNT ST SABETHA, KS 66534		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
ratio), variable INRs, history of gastrointestinal bleeding (bleeding in the stomach or digestive tract). hypertension (high blood pressure), anemia (a condition with out enough healthy red blood cells to carry adequate oxygen to the body tissue), malignancy (abnormal rapid growth of cells/cancerous growth), trauma, renal insufficiency (inability of the kidneys to excrete waste), drug to drug interactions, long duration of therapy or known genetic deficiency in CYP2C9 (human enzyme) activity*.  Review of the Drug Regimen Review monthly from 8/10/12 to 7/3/13 revealed on 8/10/12 pharmacy consultant HH noted BBW medication monitored but no further notations noted in the documentation.  Observation on 8/7/13 at 7:08 A.M. revealed the resident up and about in room, combing hair and dressed and said he/she was going down to the dining room soon. The resident had a steady gait.  Observed the resident on 8/7/13 at 3:52 P.M. resting quietly in bed, eyes closed.  Observation on 8/8/13 at 7:38 A.M. revealed the resident sat in a chair in his/her room, had a housecoat on and said he/she was waiting for a bath.  Interview on 8/7/13 with licensed nursing staff I at 4:42 P.M. said the staff wrote the BBW on the BBW for that medication on the care plan.  An interview on 8/8/13 at 2:55 P.M. with consultant HH said he/she reviewed the residents' chart for unnecessary medications		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			` ′	E CONSTRUCTION	(X3) DATE SU COMPLE		
		175376		B. WING		08/	3/2013
	OVIDER OR SUPPLIER LIC CHRISTIAN HOME	<b>E</b>		ESS, CITY, STA AMOUNT S IA, KS 6653	T .	·	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY I REGULATORY OR LSC IDENTIFYING INFORMA		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	monthly, collected dasheet, laboratory resinotes, and the history not review the reside.  The undated facility paid it was "to ensue monitored on all medicategory". The policy planning for the side medications.  Consultant HH failed the facility not monitored warning side effects for this resident.  - The electronic diagrametric	ata from the physician's ults, physician progress y and physical. He/she ents' care plans.  Policy for Black Box Wa that adverse side effectications listed under thi y failed to identify care effects for BBW  To identify the irregularization of the diverticularization of the diverticuluries pain and disturbance that y state (a mental or naracterized by tainty and irrational fear condition in which the lak backwards from the phagus), Hyperlipidemia diblood lipid levels), Sale is Disease (progressive characterized by confus and Malignant Neoplas	did rning ts are s ity of farin dated bid, nout m, in be in c), ivary sion sm	F 428			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING		(X3) DATE SURVEY COMPLETED		
		175376		B. WING		08/1	3/2013
	OVIDER OR SUPPLIER	_		ESS, CITY, STA	,		
APOSTO	LIC CHRISTIAN HOME	Ξ		RAMOUNT S IA, KS 6653			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F R LSC IDENTIFYING INFORMA	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	hopeless, tired or have behavioral symptoms wandering document diagnosis Anxiety dis (abnormal emotional exaggerated feelings and emptiness) (other medications resident days included Antian Anticoagulant medications resident days included Antian Anticoagulant medications resident had no signs did have cognition lost times and needed with his/her Alzheimes. The CAA for Psychost 11-14-12 documented anxiety at times. Hebeing nauseated or il it was usually anxiety feeling fine to not verone on one attention him/her to get up, drefelt fine and was pleas scheduled ativan (us on antidepressant.  The CAA for Psychot 11-14-12 documente history with depressions.	ving little energy. No is, rejection or care or ted. The MDS docume sorder and Depression state characterized by sof sadness, worthlession than Bipolar) and received in the last sevixiety, Antidepressant, a ations.  Sesment (CAA) for Deliricusion, disorientation and 11-14-2012 documenters of delirium. The resides but had occurred slower Loss dated 11-14-12 dent had episodes of rium noted. The residend oriented and was for cues. This was expect	ness  ven and  um d d the ent ent ent getful ed  of times n ven oax e/she k was	F 428			

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		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		175376		B. WING	<del> </del>	08/1	3/2013	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
APOSTO	LIC CHRISTIAN HOME			RAMOUNT S HA, KS 665				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 428	and was able to funct potential.  The Electronic Physic documented Ativan 0 mouth twice a day for 5-14-2012 Mirtazapin mouth daily at bedtim Warning: carefully ob 6-19-2013 Coumadin mouth six times a we Sunday, Thursday, T Atrial Fibrillation Blac major or fatal bleedin Tell caregivers to wat abnormal bruising-no 6-24-2013 Warfarin S (2 tablet/5 milligrams Monday for Atrial Fibrican cause major or faregularly. Tell caregibleeding or abnormal immediately.  Record review on 8-1 Consultant Pharmaci 7-3-13, did not identifincluding side effects  The Care Plan for Blamedications dated 12 monitor the side effect medications, to be ab medications by the lishighlighted in red, wo effectiveness of medimedications with phyefficacy and side effectoumadin, Lortab. T	cians Orders dated 5-1- 2.5 milligrams tablet by Anxietyteeth grinding te 15 milligram tablet by the for Depression Black serve patient for worse 2.5 milligram tablet by the Friday, Saturday, the Box Warning: can cat the for signs of bleeding toth for signs bruising-notify MD  12-13 revealed DRR st Review from 1-18-20 ty the need for BBW on the care plan.  ack Box Warnings (BBW toth dentified toth identified toth identified toth identified toth identified toth identified toth identified toth with physicians on	g; / / Box ning; y for nuse ly. g or ablet veek ning: NR of	F 428				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE				LE CONSTRUCTION	(X3) DATE SUF COMPLETI		
		175376		B. WING		08/13	3/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
APOSTOL	IC CHRISTIAN HOME	≣		AMOUNT S IA, KS 6653			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATIO		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	Continued From pag	je 44		F 428			
	with his/her walker. I singing activity and the singing activity and the Observation dated 8-revealed the resident difficulty. At 11:45 A without difficulty.  Licensed staff I on 8-Black Box Warnings the care plan medical had no specific side of the single side of the single side of the side o	t ambulated in the hallw Resident was walking to hen actively participated -7-2013 at 7:28 A.M. t ate breakfast without .M. the resident ate lund -8-13 at 2:52 P.M. state- were on the MAR, and tions were just listed ar	o the d. d, on				
	the resident's chart w unnecessary medica collected from the Ph laboratory results, ph history and physical.		a was and ans				
	care planning black b	Warning did not addresox warning side effects					
		ant pharmacist failed to address BBW's on the c	are				
	(abnormal emotional exaggerated feelings dejection, worthlessn	es of Depressive disord state characterized by of sadness, melanchol	y,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		175376		B. WING		08/	13/2013	
	OVIDER OR SUPPLIER LIC CHRISTIAN HOME		511 PA	RESS, CITY, STA RAMOUNT S HA, KS 665	<b>БТ</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 428	reaction characterized uncertainty and irration disorder (a major men people to have episor moods).  The Annual Minimum 5/20/13 revealed a Br Status score of 10 (in cognition).  The Care Area Assess for mood revealed immaking.  CAA for Psychotropic documented a long stancety and depression.  The signed medication Pharmacy consultant Depakote (a medication Pharmacy co	d by apprehension, and fear), and Mild Bipotal illness that causes des of severe high and.  Data Set (MDS) 3.0 dated Interview for Mental dicated moderately imposement (CAA) dated 2/2 paired daily decision.  In recertification by HH dated 5/20/13 reveon given for severe high twice a day which had BW) of nonspecific (vague uneasy feeling ess or discomfort), fevely, anorexia, facial ederunction test prior to the als for the first 6 monthing Regime Review date 2/13, and 7/3/13 failed to BW side effects on the cormation Handbook for an noted the following BI	ated baired 25/13 25/13 26/13 27/13 28/13 29/13 20/13	F 428				

DEFICIENCIES RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURVEY COMPLETED			
	175376		B. WING		08.	/13/2013		
DER OR SUPPLIER Christian Home		511 PA	STREET ADDRESS, CITY, STATE, ZIP CODE  511 PARAMOUNT ST  SABETHA, KS 66534					
(EACH DEFICIENC	CY MUST BE PRECEDED BY F	ULL	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
pservation on 8/8/1 t in the wheelchair amily member by resident.  Seensed staff I on 8-ack Box Warnings a care plan medical on specific side of the service of the second	3 at 9:15 A.M. the reside in the hallway and called in the hallway and the second in the hallway and the hallway a	ed for the d, on id stated a was and ins ved.	F 428					
	SUMMARY S (EACH DEFICIENT REGULATORY OF SIDENT)  To an anily member by resident.  Sensed staff I on 8-ack Box Warnings and no specific side of sident staff HH of the resident's chart was necessary medical elected from the Phoratory results, photory and physical. The done by nursing the undated facility procedure Black Box re planning black in the sident staff HH of the resident's chart was necessary medical elected from the Phoratory results, photory and physical. The done by nursing the undated facility procedure Black Box re planning black in the sident calls through more sident calls through more sident calls through more sident rooms; the facility reported a sed on observation stem for call light in all lights, on one of the summary of the sidents on one of the second sidents on the sidents on the sidents of the sid	DER OR SUPPLIER CHRISTIAN HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FREGULATORY OR LSC IDENTIFYING INFORMAT DONAITH OF DEFICIENCY MUST BE PRECEDED BY FREGULATORY OR LSC IDENTIFYING INFORMAT DONAITH OF DEFICIENCY MUST BE PRECEDED BY FREGULATORY OR LSC IDENTIFYING INFORMAT DONAITH OF DEFICIENCY MUST BE PRECEDED BY FREGULATORY OR LSC IDENTIFYING INFORMAT DONAITH OF DEFICIENCY MUST BE PRECEDED BY FREGULATORY OR LSC IDENTIFYING INFORMAT DONAITH OF DEFICIENCY MUST BE PRECEDED BY FREGULATORY OR LSC IDENTIFYING INFORMAT DONAITH OF DEFICIENCY MUST BE PRECEDED BY FREGULATORY OR LSC IDENTIFYING INFORMAT DONAITH OF DONAITH OF DONAITH OF DONAITH OF DOMAITH OF DOM	DENTIFICATION NUMBER:  175376  DER OR SUPPLIER CHRISTIAN HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Dontinued From page 46 DESERVATION ON 8/8/13 at 9:15 A.M. the resident at in the wheelchair in the hallway and called for armily member by name. Staff reassured the sident.  Deficiency Must be preceded by Full Regulatory on 8/8/13 at 2:52 P.M. stated, ack Box Warnings were on the MAR, and on a care plan medications were just listed and dono specific side effects.  Deficiency Staff HH on 8-8-13 at 2:55 P.M. stated be resident's chart was reviewed for an ecessary medications monthly. The data was lected from the Physician's order sheet, coratory results, physician progress notes, and story and physical. The residents' care plans are done by nursing service and not reviewed.  Defection of the Physician of the plans are done by nursing service and not reviewed.  Defection of the Physician of the care in a story and physical back Box Warning did not address are planning black box warning side effects.  Defection of the Physician of the care in a story and physical back Box Warning side effects.  Defection of the Physician of the care in a story and physical back Box Warning side effects.  Defection of the Physician of the care in a story and physical back Box Warning side effects.  Defection of the Physician of the care in a story and physical back Box Warning side effects.  Defection of the Physician of the care in a story and physical back Box Warning side effects.  Defection of the Physician of the physical back Box Warning side effects.  Defection of the Physician of the physical back Box Warning side effects.  Defection of the Physician of the physical back Box Warning side effects.  Defection of the Physical back Box Warning side effects.  Defection of the Physical Box Warni	TRECTION    175376   STREET ADDRESS, CITY, STATED   STREET ADDRESS, CITY, STATED   SABETHA, KS 6653.   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAGE	TRECTION IDENTIFICATION NUMBER:  175376  STREET ADDRESS, CITY, STATE, ZIP CODE  S11 PARAMOUNT ST  SABETHA, KS 66534  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  DISTRIBUTION ON 8/8/13 at 9:15 A.M. the resident to the wheelchair in the hallway and called for amily member by name. Staff reassured the sident.  Dense should be sufficient to the state of the st	THE CHRISTIAN HOME  STREET ADDRESS, CITY, STATE, ZIP CODE  511 PARAMOUNT ST  SABETHA, KS 66534  SUMMARY STATEMENT OF DEFICIENCES  GRACH DEFICIENCY MUST RE PRECEDED BY PILL  REGULATORY OR LSC IDENTIFYING INFORMATION)  PREPIX  SERVILLATORY OR LSC IDENTIFYING INFORMATION)  PREPIX  TAG  F 428  SERVILLATORY OR LSC IDENTIFYING INFORMATION)  FF 428  SERVILLATORY OR LSC IDENTIFYING INFORMATION)  F 428  SERVILLATORY OR LSC IDENTIFYING INFORMATION  F 428  SERVILLATORY OR LSC IDENTIFY INFORMATION  F 428  SERVILLATORY OR LSC IDENTIFY INFORMATION  SERVILLATORY OR LSC IDENTIFY INFORMATION  F 428  SERVILLATORY OR LSC IDENTIFY INFORMATION  F 428		

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NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	TE, ZIP CODE		
APOSTO	LIC CHRISTIAN HOMI	E		AMOUNT S IA, KS 6653			
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F 463	nurses' pager and di the room panel locat of 4 days on site of tl  Findings included:  - Observation on 8/6 bathroom call light for and an unsampled re CNA or licensed staff  Observation on 8/8/1 bathroom light for re activated. The CNA pagers did not trigge station did not light u  Licensed nurse I on a confirmed the call lig appropriately.  Administrative nursin A.M. revealed he/she staff EE and the call monthly.	d not trigger a visual lighted at the nurses' station he survey.  6/13 at 11:40 A.M. the presidents' #22 and #10 esident did not trigger the figager.  13 at 10:59 A.M. the sident #22 and #10 was and the licensed nurses and the licensed nurses provided by the figager.  8/8/13 at 11:05 A.M. hts were not working at the nurse provided by the figager.	0, ne s's' sees' r. 10:55	F 463			